Older Adults

Health Objectives for the Year 2010: Improve the health and quality of life for older adults.

Health Implications

The United States is experiencing an unprecedented demographic change in the makeup and size of its older population. This "longevity revolution" will make immense social and economic demands upon our nation, most particularly in the area of health care.

Since we now know that many of the negative health conditions of later years can be prevented, postponed, or eliminated through proper lifestyle management and self care, we must make prevention a core component of our health care system. Research should have an increased focus on prevention measures designed to postpone the impact of conditions or illnesses that affect loss of independence in the elderly.

Special outreach to low income and minority individuals at higher risk of illness, injury, and lost years of healthy life is imperative. Often those individuals who would benefit most from health promotion and prevention activities are the least likely to be aware of them and participate.

- By the end of this decade, the number of people aged 75 to 84 will increase by one third to 12.3 million, and people over the age of 85 will increase in number by nearly 70% to 4.9 million.
- By 2040, there may be close to 13 million people over age 85 in the United States, including 1.2 million centenarians.

In 1990, 30,853 individuals in Lancaster County, or 14.4% of the population, were 60 years of age and over. Only 2.4% of the 60+ population were from nonwhite ethnic backgrounds, 12.6% experienced disability, 34.2% were over the age of 75, and 7.4% had incomes below poverty level. During the past ten years, the country has experienced an accelerating demographic shift toward an older population with the greatest growth in that direction among minorities.

Nationally, one third of the total $1 trillion health care budget goes to people age 65 and older. By 2030, persons 65 years or older are projected to account for 21% of the United States population. In ten years, when the Baby Boom generation begins qualifying for Social Security, Medicare, and Medicaid, the vulnerability to age-related diseases will pose a significant challenge to national, state, and local communities as well as to families and individuals.

Table 1. Older Adults Indicators

	Lancaster Recent	Lancaster Objective 2010	Nebraska Recent	Nebraska Objective 2010	National Recent	National Objective 2010
Persons aged 65 and older who have difficulty in performing two or more personal care activities per 1,000 population	51.6[1]	41.0	46.6[1]	--	--	--
Injuries due to falls for persons aged 65 and older per 1,000 population	47.7[2]	38.0	--	--	--	--
Percent of persons aged 65 and older who engage in no physical activity	38.5[3]	30.8	36.8[4]	--	38.3[4]	--
Percent of persons aged 65 and older who report mental health problems in the past 30 days (stress, depression, problems with emotions)	9.9[3]	8.0	11.7[4]	--	14.5[4]	--
Percent of persons aged 65 and older who have had a professional review of all medications they are taking within the last year	--[5]	90.0	--	--	--	--
Percent of persons aged 65 and older who have participated in at least one organized health promotion program during the past year	--[6]	90.0	--	--	12.0[7]	90.0[8]

Mental and physical health and functional fitness status affect the quality of life of older adults in Lancaster County more than any other factors. This chapter will discuss information and objectives related to physical activity and functional fitness, falls and hip fractures, medication/substance use, mental health issues, and the broad category of preventive screenings and health education.

Current Status and Trends

Physical Activity & Functional Fitness

Many studies demonstrate that exercise can improve one's physical condition and extend life expectancy at any age. Much of the physical frailty attributed to aging is actually the result of inactivity. Even very frail older adults residing in nursing homes show improvement in their abilities to perform activities of daily living after participating in strength training programs.

Exercise helps to tone muscles, which improves balance and agility. It eases tension, decreases stress, and reduces depression. Regular exercise increases a person's functional fitness level, or ability to perform activities of daily living.

Exercise assists in preventing, alleviating, or managing chronic diseases, such as cardiovascular disease, high blood pressure, arthritis, osteoporosis, and diabetes.

Weight-bearing exercise, and strength training help to curb bone loss and in some cases actually increase bone mass.

Falls and Hip Fractures

The consequences of falls with the elderly are many. Eighty-seven percent of fractures occur among people aged 65 years or older and are the second leading cause of spinal cord and brain injury. Half of all elderly adults hospitalized for a hip fracture cannot return home or live independently after the fracture. Osteoporosis is a major cause of fractures.

The National Center for Injury Prevention and Control states that factors contributing to falls among the elderly include dementia, visual impairment, neurologic and musculoskeletal disabilities, psychoactive medications, and difficulties with gait and balance. Environmental hazards frequently contribute to falls. Examples of hazards are slippery surfaces, uneven floors, poor lighting, loose rugs, unstable furniture, and objects on floors. For people aged 65 and over, 60% of fatal falls occur in the home.

Injuries resulting from falls will continue as a leading cause of injury until a comprehensive, multidisciplinary, epidemiologically based prevention effort is established and maintained.

Medication and Substance Use

Lyle Bootman, dean of Pharmacy at the University of Arizona, reported to the American Medical Association in 1995 that prescription drug problems – often caused by patients not taking their drugs properly – cost an estimated $75.6 billion in medical bills and caused 119,000 deaths each year. A cost of $47.4 billion was a result of 8.8 million drug-related hospitalizations. (28% of all hospitalizations).

Prescription drug related morbidity and mortality represents a serious medical problem that urgently requires expert attention. Drug-related problems include not following directions or forgetting to take a drug, taking doses that are too high or too low, being prescribed the wrong drug, not being prescribed a drug when one is needed, and side effects ranging from rashes to death.

Older Americans compose 13% of the population yet purchase almost 30% of nonprescription drugs. In recent years the use of herbal remedies and vitamins has become more popular.

Prescription and over-the-counter drugs are sometimes used inappropriately with alcohol. This lethal combination has been referred to as a hidden epidemic in our older population. Ongoing education and individual consultations explaining the purpose of prescription and other drugs, side effects, dosages, interactions, and length of treatment are an important way to begin conquering the "polypharmacy" problem.

Since 1992, a collaborative effort has been undertaken in Lancaster County to have pharmacists review the medications of older adults in senior centers, residential facilities, and other appointed places. A study of 878 pharmaceutical interventions in five rural areas of Nebraska has also been completed. These efforts have shown the value of medication education and assessment in preventing drug-related hospitalizations, illnesses, and injuries. There is a need to adapt and expand them to meet the needs of a wider and more diverse population.

The high cost of prescription medications is a major problem for many older adults and is considered to be a public health infrastructure problem.

Mental Health Issues

Over the last decade, a striking number of articles in professional journals and the public press attest to the high prevalence of psychiatric disorders in the nations's elderly population. Depression is not a normal part of aging, but in 1996 the National Mental Health Association reported that over 58% of Older Americans think it is. Late-life depression affects some 6 million Americans, but only 10% of these persons ever get treated.

The National Center for Health reported in 1993 that older people (65+) make up the age at highest risk for suicide. Older white males are at greatest risk. Causative factors include depression, alcoholism, losses (loved ones, self-identity after retirement, financial security, health, safety, independence), social isolation, ageism, and poor coping mechanisms. While depression, a major cause of suicide, has an 80% successful treatment rate, older persons tend not to seek mental health help.

The National Mental Health Association reports that 68% of the 65+ population know little or almost nothing about depression and only 38% believe it is a health problem. Older individuals are more likely than any other group to "handle it themselves" and rarely seek help from health professionals or others.

There is a drastic need for public and professional education about aging and mental health, including information to dispel the negative myths of aging and teach successful aging. Nonthreatening depression screenings geared toward older adults could help individuals identify and deal with problems in their early stages. Mental health professionals trained to work with older adults and a local comprehensive geriatric assessment clinic would help to alleviate some of the issues related to geriatric mental health and cognitive decline problems.

Mental disorders were the fifth leading cause of acute inpatient hospitalizations in Lancaster County in 1995–96 and accounted for 7.2% of all hospitalizations. Two of the 23 suicide deaths reported in Lancaster County in 1996 were individuals 60 and over.

Preventive Screenings and Health Education

Community-based health promotion and disease prevention programs have proven to be more effective if they are developed in conjunction with the population to be served. Many older adults frequently seek out and benefit

from such programs. Increased culturally sensitive outreach efforts are needed to meet the needs of persons with mobility or access limitations or low income as well as minority individuals known to be most at risk of illness and injury.

Priority health education and screening areas relate to nutrition, mental health, home and traffic safety, cardiovascular health, diabetes, and osteoporosis. The need for cancer screenings, such as pap smears, mammogram, and prostate, are addressed in other parts of this document.

Older-adult health issues should be addressed through multiple strategies: education, counseling, screenings, environmental enhancements, and protective services. Preventing or postponing the diseases and conditions of aging in older adults can result in dramatic cost savings for the nation.

Health Disparities

Minority older persons are generally identified as members of four non-European populations: African American, Hispanic, Native American, and Asian/Pacific Islander. Nationally, minority persons constitute the fastest growing segment of the elderly population.

In recent years Lincoln and Lancaster County have seen growth in the older minority population as well as an influx of individuals from the former Soviet Union, Bosnia, Iraq, and other countries. A number of these individuals are 60 and older struggling to adjust to being a refugee or immigrant, and in need of culturally competent health services.

Ethnic and racial minority individuals in Lancaster County have significantly shorter life expectancies than nonminorities. Rates of mortality and morbidity for specific diseases vary among the various groups.

Risk factors contributing to greater morbidity and mortality among minority elders include higher rates of smoking, poor nutrition, inadequate housing, and reduced access to or use of health care and health promotion services. Despite having more problematic health conditions on average, older racial/ethnic minority individuals are less likely than nonminority elders to have health insurance or to visit a doctor.

Barriers to health improvement for certain ethnic groups include the inability to speak or read English, illiteracy in their native language, and a lack of interpreters or bilingual health care professionals. A lack of knowledge about where and how to access needed programs and services or difficulties in using the services because of distance, lack of transportation, or physical impairment also exist.

Timidity, suspicion, or reluctance to seek and accept help, possibly due to past experiences with discrimination or a concern about being labeled poor or needy, is not uncommon. Older adults who are members of racial/ethnic minority groups are frequently involved in family caregiving and are more concerned about other aspects of their lives than health unless they experience a problem.

Public Health Infrastructure

Several public health infrastructure issues pertaining to older adults have been identified. The high cost of prescription medications is foremost among these. The need for health care professionals trained to work with the expanding older adult population and the need for a local comprehensive geriatric assessment clinic are also important infrastructure issues. Currently there are very few health care professionals trained and experienced in working with older adults. Individuals must travel to Omaha or elsewhere to access a comprehensive geriatric assessment clinic.

Increased outreach and efforts to provide culturally competent health and health promotion services to low income and ethnic/racial minority older adults identified as being most at risk for illness and injury is also considered a public health infrastructure issue. Community health advocacy encompassing a commitment to health-related policy changes is necessary.

Recommendations

- Advocate for Medicare/Medicaid coverage of prescription medications for all older adults.
- Increase public awareness of issues related to the high cost of medications and polypharmacy as it relates to older adults.
- Provide more consumer education related to the proper us of prescription and nonprescription medications, alcohol and other drugs.
- Disseminate more information related to prevention and self-management in the area of mental health and mental health problems.
- Recruit and train more geriatric mental health practitioners.
- Attempt to ameliorate negative societal attitudes toward aging, which contribute to lowered self-esteem and high rates of depression.
- Improve individual participation in regular physical activity to improve functional fitness and overall physical and mental health.
- Increase outreach to low income and minority older adults.
- Plan and implement a local comprehensive geriatric assessment clinic.
- Raise public awareness of older-adult abuse issues.
- Increase the number of interpreters and bilingual health care professionals.
- Increase participation in preventive screenings and health education programs, especially among low income and minority older adults.
- Increase the percentage of older adults who receive flu and pneumonia immunizations.
- Decrease the incidence of osteoporosis through education, screenings, and assessments.
- Decrease the number of falls resulting in injury through public awareness campaigns and home assessments.

Notes

Related discussion or indicators are located in the chapters on *Chronic Disease*, *Oral Health*, *Nutrition and Physical Activity*, and *Chronic Disease*.

Table 1

-- Currently no data source.

1. U.S. Census data, 1990, special tabulation on aging. Statistics obtained from Lifetime Health/Lincoln Area Agency on Aging.
2. Lancaster County Injury Surveillance Data (E-coded emergency room data), 1992–95.
3. Lancaster County Behavioral Risk Factor Survey (BRFS), 1999.
4. Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Online Prevalence Data, 1995–98. 1998 national BRFS data from tabulation query: <http://www2.cdc.gov/nccdphp/brfs/age.asp?cat=IM&yr=1997&qkey=2604&state=US>
5. Currently no data source. Efforts by Lifetime Health, the Nebraska Pharmacists Association, and local hospitals are underway to develop a medication risk assessment tool which could be used to measure this indicator.
6. Currently no data source. Could be obtained through a community survey tool.
7. U.S. Dept. of Health and Human Services, Office of Public Health and Science, *Healthy People 2010 Objectives: Draft for Public Comment*, September 1998. 1995 data from the National Health Interview Survey, (NHIS).
8. U.S. Dept. of Health and Human Services, Office of Public Health and Science, *Healthy People 2010 Objectives: Draft for Public Comment*, September 1998.